Nursing Staff Requirements and the Quality of Nursing Home Care

A Report to the California Legislature

Governor Gray Davis
State of California

Secretary Grantland Johnson
Health and Human Services Agency

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I. BACKGROUND

A. Purpose of This Report

Overview of Nursing Homes in California

On any average day, approximately 100,000 Californians reside in skilled nursing facilities (SNFs). Approximately 70 percent of them are age seventy-five and older. For many, this is a temporary placement only -- approximately 80 percent of residents are discharged within six months. However, those residents with serious or chronic health conditions may reside in a skilled nursing facility for several years.

State law defines a SNF as providing continuous skilled nursing care and supportive care on an extended basis. Such care comprises twenty-four hour inpatient care, including physician, skilled nursing, dietary, pharmaceutical services, and an activity program. Federal law describes the purpose of a nursing home as bringing "each resident to the highest practicable level of mental, physical, and psychosocial well-being, and to do so in an environment that emphasizes residents' rights."

At present, there are 1,187 licensed freestanding skilled nursing facilities and 237 SNFs that operate as a distinct part of a general acute care hospital. In 1998, Californians spent over $4.4 billion on skilled nursing facility care, 60 percent of which was paid for through the state's Medi-Cal program.

In the last several years, the public, the media, and federal and state policy-makers have given increasing attention to the question of how to ensure a higher level of quality care for the residents of nursing homes. Recently, both within California and on the national stage, policy-makers have questioned whether nursing homes are sufficiently staffed to provide quality care.

Mandate for the Report

In January 2001, AB 1731, Shelley (Chapter 451, Statutes of 2000) took effect. The legislation was a key component of the comprehensive "Aging with Dignity Initiative," sponsored by Governor Gray Davis to improve services to the elderly and to implement significant nursing home reform. Among the stated purposes of AB 1731 was to ensure that SNFs in California provide safe and secure environments for residents and their families and that they have the highest quality of care possible. AB 1731 also states the intent of the Legislature to "establish sufficient staffing levels required to provide quality skilled nursing care."

California Health and Safety Code Section 1276.7 directs the Department of Health Services (DHS) to prepare a report on or before May 1, 2001, assessing the need, and providing subsequent recommendations, for any increase in the minimum number of

nursing hours in SNFs required to provide California nursing home residents with a safe environment and quality skilled nursing care. (See Appendix B.)

This report approaches the legislative mandate by reviewing:

- The national dialogue regarding staffing standards and the quality of care.

- Implementation of the current California requirement. (Effective January 2000, the minimum nursing staff requirement in skilled nursing facilities was raised to 3.2 hours of direct care per patient day.)

- Policy issues regarding nursing staff requirements raised in the literature and financial implications of changing the current standard.

Sources of Data

The findings and recommendations presented are based on the following sources of data:

- Materials submitted upon invitation from identified stakeholders. Invitations to submit relevant information on this topic were sent to a list of over sixty-five individuals or organizations that have been recognized as opinion leaders or researchers in the area of nursing home care within California or nationally. (See Appendix C.)

- Selected reports and articles published in the last decade about nursing home staffing standards, consequences of low staffing, and other related quality of care concerns. (See Bibliography in Appendix D.)

- Financial and utilization data on nursing homes from the Office of Statewide Health Planning and Development.

- Information drawn from a sample of 111 skilled nursing facility surveys completed between January 1 and February 16, 2001. During this period, for all SNFs surveyed DHS directed surveyors to calculate the average nursing staff hours per patient day for the week preceding the survey. The sample proved representative of roughly the same proportion of nonprofit to proprietary facilities as exists overall.

- Data from the Licensing and Certification Program Automated Certification and Licensing Administrative Information Management System (ACLAIMS) and the federal On-line Survey Certification and Reporting System (OSCAR).

- Medi-Cal Program cost data.

It should be noted that the timeline given for this report precluded the opportunity for DHS to conduct or contract for original scientific research.

B. National Context

California Has Third Highest Staffing Standard in the Country

Since OBRA's passage in 1987, thirty-five states have adopted nursing staff requirements to augment the general federal nursing standard. Of these, fifteen (including California) are considered to have "more demanding standards."[1]

Currently, only Arkansas and Delaware have more stringent staffing requirements than California (3.2 hours/patient day) for standard SNFs. As of May 2000, Delaware requires 3.25 hours of nursing care per patient day. In Arkansas, legislation slated to take effect in September 2000, required staff-to-patient ratios that are equivalent to 3.5 hours per patient day.

Prior Requirement: Chapter 502, Section 3, Statutes of 1990, set in place minimum nursing staff requirements for California nursing homes that remained unchanged for almost a decade. The Legislature directed the Department of Health Services (DHS) to establish regulations that would increase the minimum number of nursing hours required per patient day in skilled nursing facilities over a three-year period to 3.0 hours per patient day with doubled nursing hours. This policy in statute of doubling nursing hours enabled the actual hours of patient care provided by licensed and registered nurses to count twice as much as the hours provided by certified nursing assistants toward meeting the 3.0 requirement.

For example, in Facility A, patients may have been receiving 57 minutes of registered or licensed nurse attention each day (.95 hours per patient day), and 66 minutes of nursing assistant attention (1.1 hours per patient day) for a total of 2.05 actual hours per patient day in actual care. In Facility B, patients may have received 36 minutes of registered or licensed nurse attention (.6 hours per patient day), and 108 minutes of nursing assistant care (1.8 hours per patient day) for a total of 2.4 actual hours per day. In both cases, once the licensed nursing hours were added twice to the actual hours per patient day, the facility would have been compliant with the 3.0 hours per day, with doubled nursing hours requirement. For Facility A, twice the licensed nurse hours (.95+.95=1.9 hours) added to the CNA hours (1.1 hours) comes to 3.0 hours per patient day. Likewise, for Facility B, twice the licensed nurse hours (.6+.6=1.2 hours) added to the CNA hours (1.8 hours) comes to 3.0 hours per patient day.

Current Requirement: In response to concern over relatively low levels of direct patient care staff and quality of care in nursing homes, Governor Gray Davis signed Chapter

[1] U.S. Health and Human Services Agency, Health Care Financing Administration, *Report to Congress: Appropriateness of Minimum Staffing Ratios in Nursing Homes* (Washington, D.C.: GPO, 2000), 2-20 [HCFA *Report to Congress*]

146, Section 33, Statutes of 1999, which increased the minimum nursing staff requirement to 3.2 hours of direct patient care per day effective January 2000. This legislation also eliminated the doubling policy of allowing licensed or registered nurse hours to be counted double.

It is important to note how this hours per patient day standard applies in practice. Over the course of twenty-four hours, it is required that the facilities provide an average of 3.2 hours of nursing staff for each resident. If a facility has 100 patients, it must record in its attendance and payroll records that staff were assigned to provide 320 hours of direct patient care during each day. One patient may be provided 4.4 hours of direct care during the course of the day, while another may be provided 2.0 hours – as long as the average throughout the facility is 3.2 hours during that twenty-four hour period. The standard does not assure that any given patient receives 3.2 hours of nursing staff care.

Other States

The states vary widely in their approach to standards. Of the thirty-five states that have established state staffing standards, twenty-four define them by required hours per patient day, seven by required patient-to-staff ratios, and four define them with both hours per patient day and patient-to-staff ratio requirements. Twenty-six states have a requirement for licensed nurse staffing that exceeds the federal standard. Twelve have requirements that specifically address staffing by shift. (See Appendix E for detail about other states' staffing requirements.)

Congressional Mandates

In 1987, the Nursing Home Reform Act (also referred to as the Omnibus Budget Reconciliation Act of 1987, or OBRA) established the current federal standard for staffing. This standard states that each nursing home must provide twenty-four hour licensed nursing services that are sufficient to meet the nursing needs of its residents, and must use the services of a registered professional nurse for at least eight consecutive hours a day, seven days a week. This standard of "sufficiency," however, has been criticized as too vague to enforce.[2]

In 1990, Congress directed the U.S. Department of Health and Human Services to study and report to Congress on the appropriateness of establishing minimum supervisor to caregiver to resident ratios and provide recommendations. As discussed below, results of Phase One of the study were released in 2000.

[2] HCFA *Report to Congress*, 1-4 and 2-19

Health Care Financing Administration (HCFA)[3]

HCFA is a federal agency within the United States Department of Health and Human Services. HCFA runs the Medicare and Medicaid programs and maintains oversight of the survey and certification of nursing homes and continuing care providers (including home health agencies, intermediate care facilities for the mentally retarded, and hospitals).

In 1998 and 1999, public and congressional concerns about nursing home staffing were elevated by several reports from the U.S. General Accounting Office, the U.S. Department of Health and Human Services' Office of Inspector General, and in hearings held by the U.S. Senate Special Committee on Aging, which identified significant concerns regarding care in nursing homes.[4] In June of 2000, both in response to its original mandate and to criticism raised by the reports and public concern, HCFA published the results of "Phase One" of its study in a *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*.

The Phase One study included three research strategies: 1) review of prior research and expert consensus evaluation of that research; 2) empirical determination (multivariate analysis) of the relationship between staffing and care outcomes (defined several ways); and, 3) a time-motion study of five key care processes performed by nursing assistants as a basis for setting nursing staff standards (assistance with feeding, grooming, toileting, exercise, and medications).

While HCFA proposes to provide definitive recommendations regarding minimum staffing requirements in its Phase Two report, the Phase One findings indicated:

> "For virtually all types of nursing staff, there is some ratio of staff to residents below which residents are at substantial risk of increased quality problems."[5]

Phase One findings also indicate that it is possible to identify significant staffing thresholds. The first threshold, HCFA's "Minimum Staffing Level," is identified as the threshold below which care of residents is likely to be compromised. On the basis of examining the levels of nursing staff and outcomes of care at a large number of nursing homes in three states, and adjusting for resident risk, this threshold was identified to be 2.75 hours of nursing care per patient day (2.0 hours of nursing assistant care and .75 hour of licensed or registered nurse care per patient day).

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[3] On June 13, 2001, the U.S. Health and Human Services Agency announced that the agency called the Health Care Financing Administration has been newly named The Centers for Medicare and Medicaid Services.

[4] U.S. General Accounting Office, *Nursing Homes: Sustained Efforts Are Essential to Realize the Potential of the Quality Initiatives,* GAO/HEHS-00-197 (Washington D.C.: GPO, 2000), 5

[5] HCFA *Report to Congress,* 9-16

The second threshold, HCFA's "Preferred Minimum Level," is identified as a threshold at which by examining similar measures as were studied to determine the 2.75 standard, "quality was improved across the board."[6] The Preferred Minimum Level is 3.0 hours of nursing care per day (2.0 hours of nursing assistant care, and 1.0 hour of licensed and/or registered nurse care).

HCFA also attempted to determine, through time-motion studies, how long it takes for a nursing assistant to provide daily care services with optimal quality. By measuring the length of time that each of five critical daily care processes required to complete and developing a profile for the "average" nursing home in terms of the levels of care that residents might require (and thus an expectation for what kinds of patient needs the average nursing assistant would need to meet), the researchers arrived at the conclusion that 2.9 hours of nursing assistant care per patient per day would be necessary to provide optimal care. HCFA did not conduct a similar time-motion study for nurses.

The Phase One report did not include any recommendations for the establishment of a new federal staffing requirement, in part because 54 percent of nursing homes nationwide currently would not meet even the "Minimum Staffing Level" (HCFA's first threshold).[7] (In California, 42 percent of SNFs would not have met this standard in 1999.[8] As discussed further in the next section, however, in California this percentage appears to be decreasing and staffing levels appear to be rising.) HCFA has deferred minimum nurse staffing recommendations until the Phase Two report, the research for which is currently underway.

Institute of Medicine

Since 1970, the Institute of Medicine (IOM) has acted under the charter of the National Academy of Sciences to identify issues of medical care, research, education and other health policy matters.

In 1996, the IOM published *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* in which it concluded:

> "The preponderance of evidence, from a number of studies, using different types of quality measures, shows a positive relationship between nursing staff levels and quality of nursing home care, which in turn, indicates a strong need to increase the overall level of nursing staff in nursing homes."[9]

[6] HCFA *Report to Congress,* E.S.-5

[7] HCFA *Report to Congress*, 12-5

[8] Extrapolated from Office of Statewide Health Planning and Development's *Long-Term Care Annual Financial Data, for Reports Ended January 1, 1999 through December 31, 1999*. Available on the Internet at www.oshpd.ca.gov.

[9] Institute of Medicine, Division of Health Care Services, *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* Gooloo S. Wunderlich, Frank A. Sloan, and Carolyne K. Davis, editors. (Washington, D.C.: National Academy Press, 1996), 153. [IOM 1996]

The report, however, did not suggest appropriate levels of nursing staff, noting that the research literature did not define an optimal staffing level, nor how to account for varying circumstances among nursing homes, including differences in the types of care needed by individual facilities' residents (also referred to as "case-mix").

In another report published in December 2000*, Improving the Quality of Long Term Care*, the Institute reiterated:

> "Abundant research evidence indicates that both nursing-to-resident staffing levels and the ratio of professional nurses to other nursing personnel are important indicators of high quality of care ... The research literature, however, does not answer the question of what particular skill mix is optimal. Nor does it take into account possible substitutions for nursing staff and ways to best organize all staff. Moreover, nurse staffing levels alone are a necessary, but not a sufficient, condition for positively affecting care in nursing homes."[10]

In its December report, the IOM also calls for the federal government to develop minimum staffing levels (that specify number and skill mix) for direct care that are based on case mix-adjusted standards. To develop these standards, the Institute recommends that the U.S. Department of Health and Human Services fund research to examine the actual time and staff mix required to provide adequate processes and outcomes of care consistent with the needs and variability of consumers in these settings.

Hartford Conference Panel of Experts

In April 1998, a one-day conference was convened at the John A. Hartford Institute for Geriatric Nursing, Division of Nursing at New York University to address the issue of staffing and quality of care in nursing facilities. National experts attending the conference included leading nurse researchers, educators and administrators in long-term care, consumer advocates, health economists, and health services researchers. The panel's majority opinion was published in 2000 in an article in *The Gerontologist* by Charlene Harrington, Ph.D., RN, FAAN; Christine Kovner, Ph.D., RN, FAAN; Mathy Mezey, Ph.D., RN, FAAN; Jeanie Kayser-Jones, Ph.D., RN, FAAN; Sarah Burger, RN, MPH; Martha Mohler, RN, MN, MHSA; Robert Burke Ph.D.; and, David Zimmerman, Ph.D.

[10] Institute of Medicine, Division of Health Care Services, *Improving the Quality of Long-Term Care*. Gooloo S. Wunderlich and Peter Kohler, editors. (Washington, D.C.: National Academy Press, 2000), 9. [IOM 2000]

The panel of experts reviewed four sources of information:

- Previous studies on staffing and quality of care;
- Current nurse staffing levels using data from OSCAR;
- Federal staff time management studies on nursing care in nursing homes; and,
- The minimum standard recommended by the National Citizens' Coalition for Nursing Home Reform (NCCNHR).

On this basis, the panel endorsed the NCCNHR standard with slight revision. This standard equates to 4.13 hours of direct nursing care per day. However, the panel also identified the need for additional research:

> "…. Current data show that the average nurse staffing levels (for RNs, LVN/LPNs, and NAs) in nursing homes are too low in some facilities to provide high quality of care. … Because detailed time studies have not been conducted on the amount of time that is required to provide high quality of care to residents, expert opinion is currently the best approach to addressing the problem of inadequate staffing. … Additional research is needed to determine appropriate levels and types of staff to provide high quality of care to residents."[11]

It should be noted at this point that the NCCNHR recommended standard is significant because it is intended to move toward the federal goal of "highest practicable level" of resident well-being, rather than maintaining a level that only ensures avoidance of poor quality care.[12]

[11] Harrington, Charlene, Ph.D., R.N. FAAN, et.al, "Experts Recommend Minimum Nurse Staffing Standards for Nursing Homes in the United States," *The Gerontologist* 40, no.1 (2000): 14

[12] National Citizens' Coalition for Nursing Home Reform, "Development of Consumer Minimum Staffing Standard for Nursing Homes" (fact sheet available at www.nccnhr.org)

Summary of Current Minimum Nursing Staff Proposals

Table 1 on the following page summarizes the various minimum nursing staff proposals discussed in this chapter.

TABLE 1: SUMMARY OF MINIMUM NURSING STAFF PROPOSALS

Source of proposal	What is proposed?	How was it derived?
Health and Safety Code Section 1276.7	3.5 nursing staff hours of care per patient day (hppd) by 2004 (or to staffing levels that DHS determines are required to provide California nursing home residents with a safe environment and quality skilled nursing care.)	Unknown
HCFA (first threshold: Minimum Staff Level)	2.0 CNA hppd .75 Licensed nurses hppd (with .2 RN hppd) (2.75 hppd total)	Multivariate analysis of staffing levels related to minimize frequency of negative care outcomes
HCFA (second threshold: Preferred Minimum Level)	2.0 CNA hppd 1.0 Licensed nurses hppd (with .45 RN hppd) (3.0 hppd total)	Multivariate analysis of staffing levels related to increased frequency of quality care outcomes
HCFA (time-motion study of optimal CNA staffing only)	2.9 CNA hppd	Time motion study of 5 critical CNA care processes adjusted for an "average" residents' needs mix
Hartford Conference Panel of Experts	Direct care staff: 1:5 patients day 1:10 patients afternoon 1:15 patients night Licensed nurses: 1:15 patients day 1:20 patients afternoon 1:30 patients night (4.13 hppd total)	Previous studies on staffing and quality of care; current nurse staffing levels using data from OSCAR; federal staff time management studies on nursing care in nursing homes; and, the minimum standard recommended by the National Citizens' Coalition for Nursing Home Reform (NCCNHR)

II. COMPLIANCE WITH THE CURRENT REQUIREMENTS

A. Implementation of the New State Requirement

The requirement for California's skilled nursing facilities to provide a minimum of 3.2 nursing hours per patient day took effect on January 1, 2000. In recognition of the impact of the increase in terms of recruiting new staff during a nursing shortage, the Department of Health Services (DHS) notified all SNFs that on or shortly after April 1, 2000, they would be expected to be in full compliance.[13] DHS updated its procedures and forms for computing nursing hours per patient day and, in February 2000, distributed them to the district offices responsible for surveying activities.

DHS enforces the 3.2 staffing requirement primarily through on-site reviews of SNFs in response to complaints filed against facilities, and during routine periodic licensing and certification surveys when other findings suggest that staffing may be an issue. If a facility is found out of compliance with the 3.2 standard, DHS may issue a deficiency or a citation, depending on the impact on patient care. Both a deficiency and a citation require the facility to prepare and implement an acceptable plan of correction. A citation also carries with it imposition of monetary fines.

B. Assessing Compliance

Compliance with the Current 3.2 State Standard

Since DHS did not begin enforcement of the 3.2 hours per patient day standard until April of 2000, less than a year of actual experience was available for review under the new requirement for this report. Data from the Office of Statewide Health Planning and Development (OSHPD) for the year 2000 is not yet available. Accordingly, DHS used data from its surveys of 111 SNFs conducted in January and February 2001 to gauge current compliance with the standard. For purposes of comparison, DHS used OSHPD data to assess staffing levels in 1999[14], even though the 3.2 hours per patient day was not the standard.

In 1999, 97 percent of California SNFs met the then-current 3.0 staffing standard (which allowed for doubling the value of licensed nurse hours). In the sample taken for the first six weeks of 2001, 67 percent were staffing at an average of 3.2 hours per patient day during a one-week period at the time of the survey. It should be noted that the potential

[13] Klutz, Brenda G., memorandum on behalf of the California Department of Health Services to All Skilled Nursing Facilities, January 12, 2000.

[14] Extrapolated from Office of Statewide Health Planning and Development's *Long-Term Care Annual Financial Data, for Reports Ended January 1, 1999 through December 31, 1999*. Available on the Internet at www.oshpd.ca.gov.

impact of labor shortages, or funding limitations on facility efforts to achieve the 3.2 nursing hours per patient per day is beyond the scope of this study. However, it is important to note that since the Legislature enacted the 3.2 staffing standard, there appears to have been a significant increase in the levels of staffing throughout the industry, as shown in Figures 1 and 2. In 1999, under the prior requirement, 25 percent of SNFs had actual nursing staff hours per day of 3.2 or more. By 2001, 67 percent show average staffing at 3.2 or more hours per day, based on the sample of 111 facilities.

Figure 1

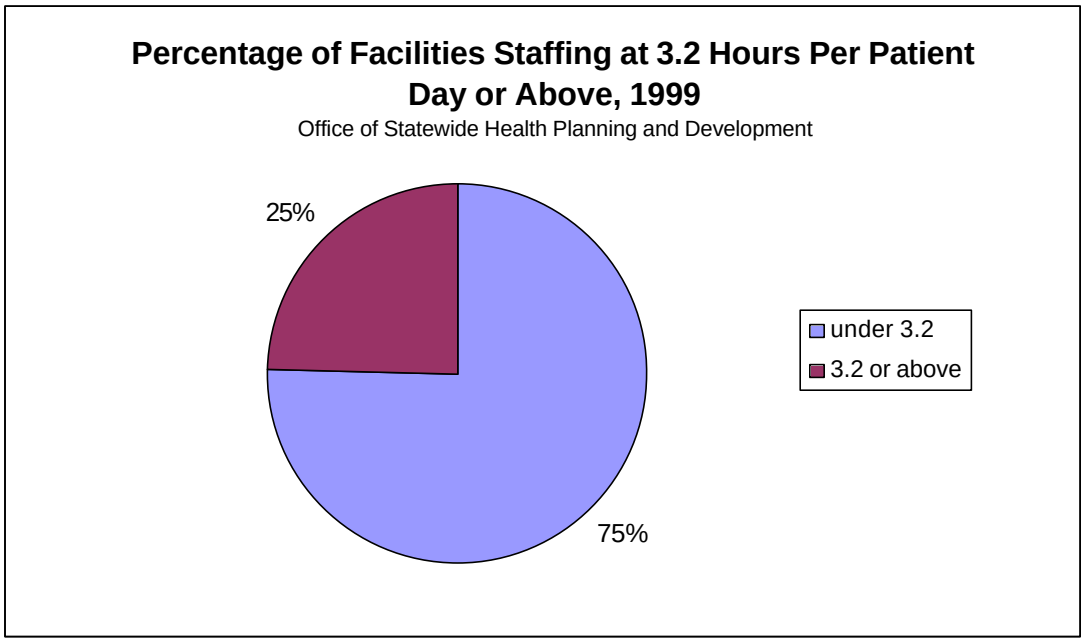
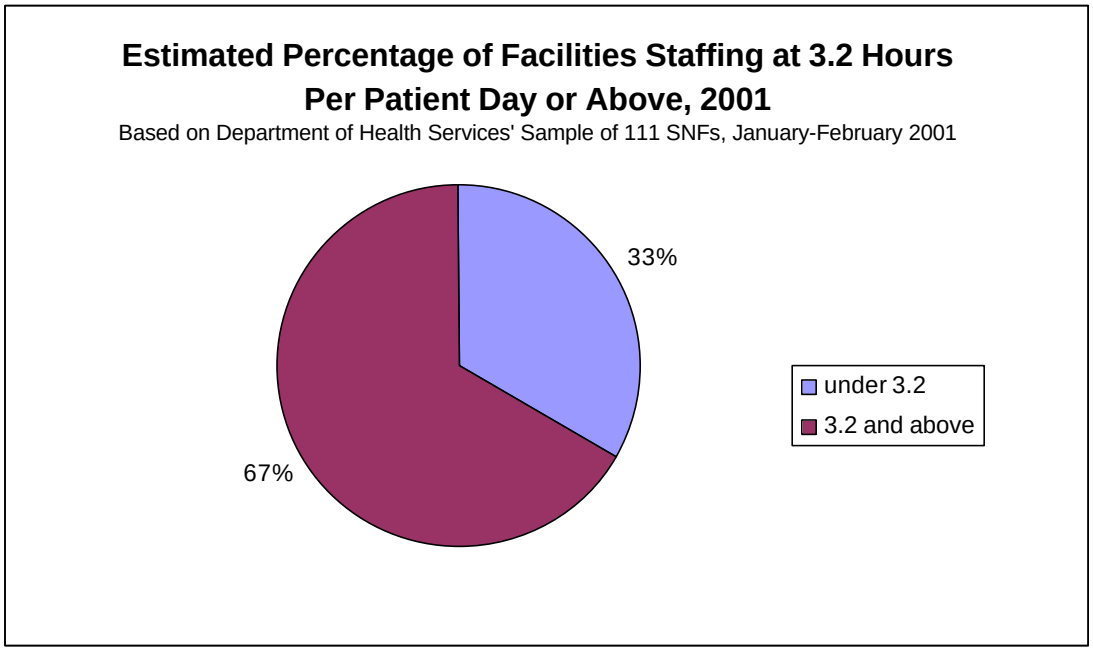


Figure 2



In terms of documented violations of the state requirement, 145 violations were identified in 1999; in 2000, this increased to 163. Further, in 1999 two monetary fines were levied for violations of the state requirement. One was an “A” citation (meaning that the violation presented imminent danger or serious probability of death or serious harm); the other a “B” (meaning it has a direct or immediate relationship to the health, safety, or security of a patient or resident). In 2000, one “A” citation, and five “B” citations were issued for violations of the state requirement.

In the sample of 111 SNF surveys completed in the first seven weeks of 2001, thirty-eight SNFs were found to have staffed at an average of less than 3.2 hours per patient day. Thirty-seven received staffing related deficiencies, and one received a “B” citation.

Compliance with the Federal Standard

The federal standard does not require specific staffing levels for SNFs, either in terms of hours per patient day or staff-to-patient ratios. Rather, as noted on page 3, the federal standard addresses a staffing level "sufficient" to meet the nursing needs of residents. Violations of the federal staffing requirement relate to adverse resident outcomes – that is, quality of care can be proven to have been in some way compromised specifically by insufficient staffing – not whether California’s SNFs are meeting the minimum requirement for 3.2 hours per patient day. In fact, it is possible to violate the federal staffing standard and meet the state requirement; or, conversely, to meet the federal standard but violate the state requirement.

For example, a Licensing and Certification survey team may find that a facility meets the state 3.2 hours per patient day standard but, because its patients need a higher level of staffing, the team may find adverse patient outcomes resulting in the issuance of federal staffing deficiencies. On the other hand, a survey team may cite a violation of the 3.2 standard but, because no adverse patient outcomes are noted, no federal deficiencies for insufficient staffing are issued.

In 1999, 159 federal deficiencies were issued for insufficient staffing. In 2000, 113 federal deficiencies for insufficient staffing were issued. The majority of violations in both years were at levels that would not be considered to reach the federally defined threshold of “substandard quality of care.” In 2000, the percentage of federal deficiencies issued for staffing violations that did constitute substandard quality of care (30 percent) was significantly lower than in 1999 (43 percent). In fact, deficiencies that constitute “substandard quality of care” were down overall between 1999 and 2000. In 1999, 437 deficiencies were issued for substandard quality of care. In 2000, surveyors issued 316 deficiencies at that level – down a difference of 28 percent.

Relationship of Staffing to Ownership Type and Medi-Cal Census

The mandate for this report specifically requests an analysis of the relationship between staffing and facility corporate status (or "ownership type") and between staffing and number of Medi-Cal beds.

Staffing by Type of Ownership: With regard to ownership types, DHS analyzed the differences between proprietary and nonprofit/governmental SNFs. Proprietary SNFs dominate the California market. In 1999, they comprised approximately 87 percent of the total SNFs in California (1029 of 1187 total). In the 2001 sample of 111 SNFs, proprietary facilities comprised 89 percent of the total (99 of 111).

Figure 3 on the following page compares nonprofit and proprietary facilities in terms of actual nursing staff hours per patient day in 1999. In the DHS staffing sample of 111 SNFs, 91 percent of nonprofit facilities were staffing at an average of 3.2 hours per patient day or more, compared with 63 percent of proprietary facilities. See Figure 4 on following page.

Staffing by Medi-Cal Volume: With regard to Medi-Cal volume, the data indicate that proprietary facilities tend to serve a larger proportion of Medi-Cal beneficiaries -- 72 percent of proprietary SNFs have a Medi-Cal population that comprises more than 60 percent of total population, as opposed to 26 percent of nonprofit facilities. The data displayed in Figure 5 (see page 16) indicates that the higher the proportions of Medi-Cal residents in a facility's resident population, the lower the average nursing staff hours per patient day.

C. Summary of Findings

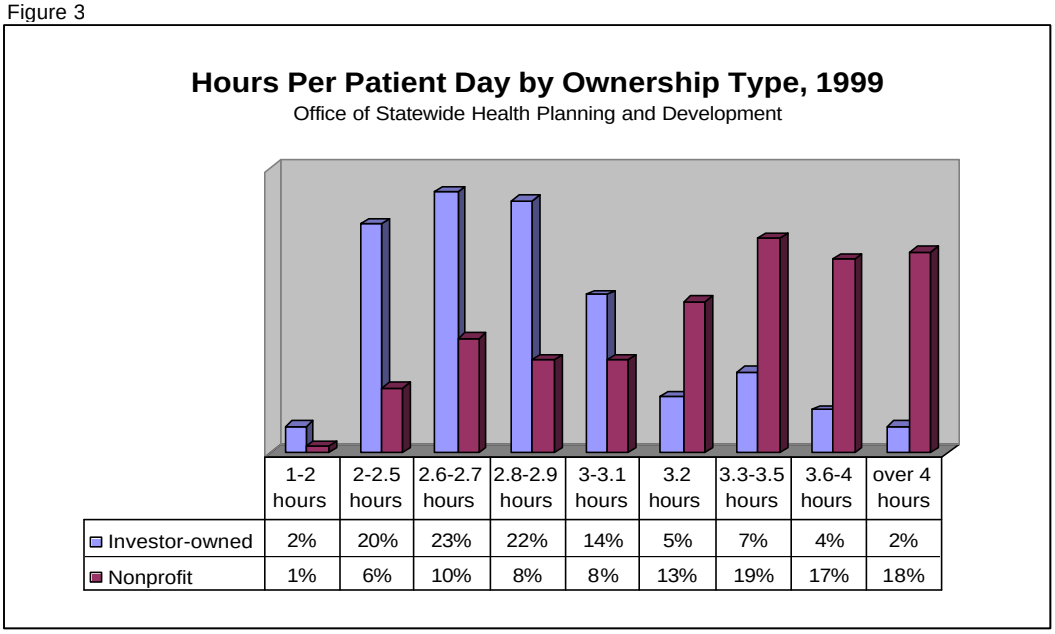
The analysis that DHS was able to conduct in the time available does not lead to any conclusive findings. However, the data suggest the following:

- Staffing levels have increased significantly since implementation of the 3.2 nursing hours per patient day standard, however 33% of sampled nursing facilities did not meet the minimum requirement.

- Deficiencies for federal "substandard quality of care" have decreased overall since implementation of the 3.2 standard.

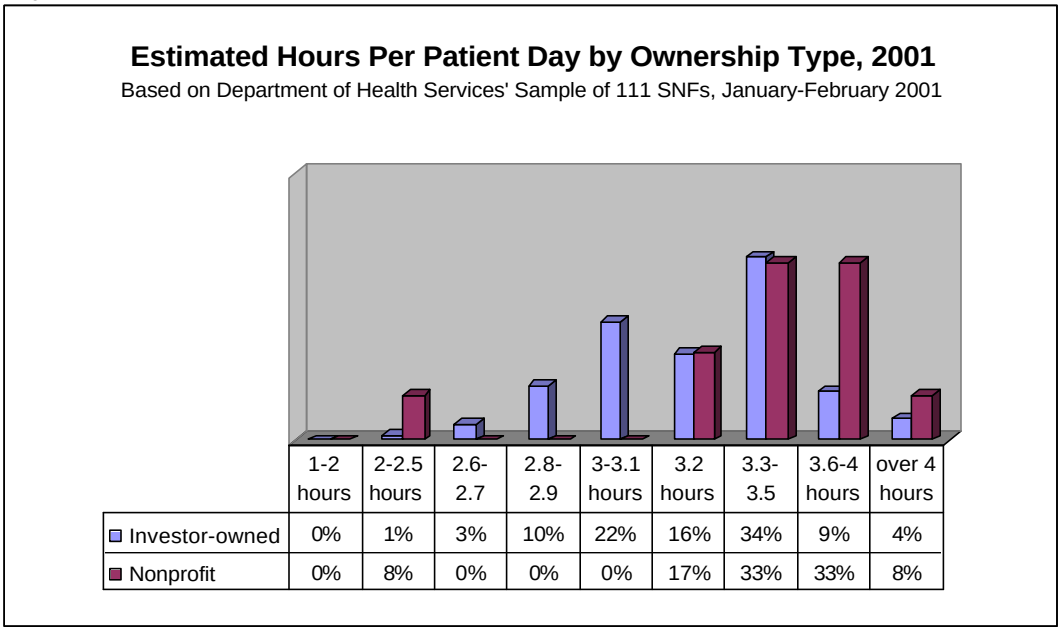
- Facilities that provide care to higher proportions of Medi-Cal residents are less likely to provide higher levels of staffing.

Figure 3



	1-2 hours	2-2.5 hours	2.6-2.7 hours	2.8-2.9 hours	3-3.1 hours	3.2 hours	3.3-3.5 hours	3.6-4 hours	over 4 hours
Investor-owned	2%	20%	23%	22%	14%	5%	7%	4%	2%
Nonprofit	1%	6%	10%	8%	8%	13%	19%	17%	18%

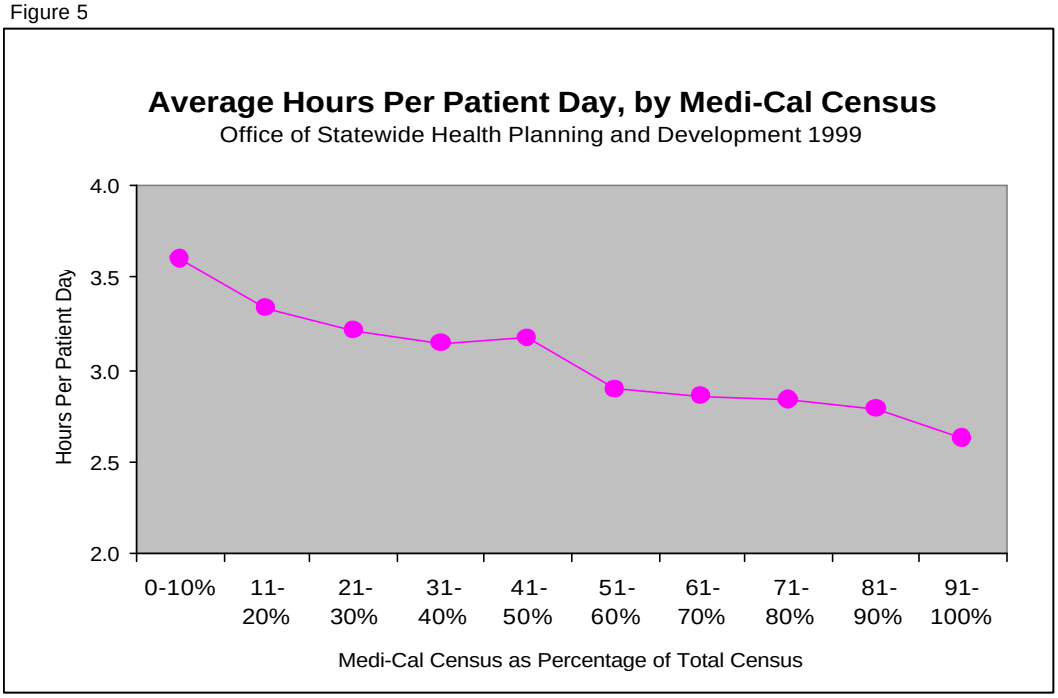
Figure 4



	1-2 hours	2-2.5 hours	2.6-2.7	2.8-2.9	3-3.1 hours	3.2 hours	3.3-3.5	3.6-4 hours	over 4 hours
Investor-owned	0%	1%	3%	10%	22%	16%	34%	9%	4%
Nonprofit	0%	8%	0%	0%	0%	17%	33%	33%	8%

Note: In Figures 3 and 4, the percentage totals for each ownership type may be slightly less than 100 percent due to the effect of rounding.

Figure 5


Average Hours Per Patient Day, by Medi-Cal Census
Office of Statewide Health Planning and Development 1999
Hours Per Patient Day
4.0
3.5
3.0
2.5
2.0
0-10%
11-20%
21-30%
31-40%
41-50%
51-60%
61-70%
71-80%
81-90%
91-100%
Medi-Cal Census as Percentage of Total Census

III. POLICY CONSIDERATIONS REGARDING NURSING STAFF STANDARDS

The relationship of nursing staff requirements to quality of care is highly complex. The federal "sufficiency" standard results only in the issuance of sanctions when the adverse effects of low staffing can be identified. There are many factors affecting SNF quality of care that require careful consideration. Adequate nursing staff is a necessary, but not sufficient component of an effective strategy to achieve this goal.

Defining "Quality"

A fundamental policy issue is "what resident outcomes *do* constitute the highest practicable level of mental, physical and psychosocial well-being?" Or, more simply put, "what are we trying to achieve for nursing home residents?"

The population of nursing home residents is very ill, very frail, and often disoriented. While research has identified staffing levels below which the likelihood of negative care outcomes increases significantly, it is not as conclusive with respect to what positive outcomes are possible with this population, even given an optimum staffing level. Without definitive data to predict what outcomes might be possible at different staffing levels, it is difficult to determine what minimum staffing levels should be required or to assess whether the quality of care goal of the minimum standard is being achieved.

Even if an appropriate definition of "quality" was available, government policy-makers must recognize that government alone cannot achieve its implementation. Such a challenge requires cooperation among various social sectors including facility owners and administrators, organized labor, the educational community, the research community, long-term care insurers, and families.

In addition, many studies suggest that other factors, as well as nursing staff levels, are important in ensuring a higher quality of care for nursing home residents.

Acuity and Case-mix

Nursing home residents have individual care needs: some have higher levels of "acuity" (that is, their needs for nursing care are greater) than others. The acuity of residents in one facility may generally be greater than in another: this variation within a resident population is referred to as "case-mix". The case-mix of an individual facility may vary from week to week.

A minimum staffing standard does not take into consideration either the acuity of individual residents or the case-mix of any individual facility. In studies regarding

nursing staff requirements, higher or lower thresholds are identified as necessary for residents with different categories of care needs.[15] The time-motion based standard for optimal nurse assistant hours developed for HCFA (see page 6), for example, while adjusted to allow for different levels of care to different residents, was still constructed on the estimated needs of the "average" case-mix of a skilled nursing facility.

While some researchers and advocates indicate that a staffing requirement based on individual resident acuity or facility-specific case-mix would be ideal, the technology to calculate and enforce such a requirement does not presently exist.

Shift Differences

Nursing home residents require different levels of care at different times of the day. There are significant differences in the duties and workload of each standard eight-hour shift in a nursing home. For example, during the day shift (typically from 7 A.M. until 3 P.M.), the majority of residents must be assisted with the activities of daily living (grooming, toileting, etc.), receive medications, and be given breakfast within a certain time of waking. During the same shift, they are most likely to be active through the morning and receive lunch before three. This is a particularly intensive time of day in terms of the care needs of residents. On the night shift (typically 11 P.M. until 7 A.M.), residents still require attention, including, among other things, incontinence care, pressure ulcer prevention, tracheotomy care; and it is not uncommon for patients with dementia or Alzheimer's Disease to have increased confusion during the night hours. Adequate staffing on the night shift is as important as during the day, but the number of staff needed to provide care can be very different.

Staff-to-Patient Ratios versus Hours per Patient Day

Minimum staffing requirements are expressed either in terms of the average number of hours of nursing care per patient each day or in terms of the number of patients each nursing staff person is required to care for (staff-to-patient ratios). The current California requirement of 3.2 hours per patient day is roughly equivalent to an average ratio of one direct caregiver (CNA, LVN or RN) to seven and a half patients over the course of a twenty-four hour period.

However, this number is for discussion purposes only and should not be considered strictly comparable to shift and skill mix defined ratios. It would not be reasonable to expect 3.2 hours per patient day to equate to a ratio where each care giver is typically working with only seven or eight residents, considering that staffing may be necessarily richer at some points of the day and less rich at others. Also, typically, each CNA is working with a set number of residents. During that same period of time each licensed nurse is working with a set number of residents which may include some of the same residents at once.

[15] See, for example, HCFA *Report to Congress*, 12-5; IOM 1996, 147

Both ratios and the hours per patient day approach are useful to facilities and to consumer advocates as guidelines for the level of nursing care that should be provided. Both approaches allow facilities the flexibility to allocate staff according to the needs of individual residents, and the skills and experience of the staff. Both can be effectively enforced by the regulatory agency. Neither ensures that available staff actually provide appropriate care.

Skill Mix of Direct Care Staff

Three types of nursing staff provide care in nursing homes: registered nurses (RNs), licensed vocational nurses (LVNs), and certified nurse assistants (CNAs). Each nursing staff category has different levels of training. RN training can be accomplished in several ways, including through a four-year baccalaureate degree, a three-year hospital diploma program, or a two-year associate degree; LVN training is most typically a year in duration and conducted through a community college or adult vocational education program; and CNAs receive 160 hours of initial training. Nurses are trained and prepared to perform complex care functions and to evaluate outcomes in a way that CNAs are not. For example, only a nurse can administer medications or develop an individualized plan of care. For purposes of meeting California's hours per patient day standard, there is no distinction between these three nursing categories -- though scopes of practice standards limit what services CNAs can provide.

Many studies suggest that skill mix of direct care staff is at least as important to ensuring positive care outcomes as staffing levels. CNAs provide between 60 to 80 percent of the direct care that nursing home residents receive. While their role is critical to the well being of residents, several studies specifically correlate higher registered or licensed nurse ratios with better patient outcomes.[16]

Some studies also suggest that a proper ratio of licensed nurses (RNs and/or LVNs) to CNAs is as critical in terms of supervision as for direct care. Since the turnover rate for CNAs is quite high, appropriate supervision and professional guidance for CNAs takes on critical importance. (The national average annual turnover rate for CNAs has been reported as high as 100.4 percent.[17] In other words, within one year a facility that normally operates with sixty CNAs on staff at any given time would have lost and hired at least sixty CNAs.)

Nursing Staff Shortage

California currently faces a serious nursing workforce shortage. The state is expected to need 25,000 additional nurses to meet the projected demand for nursing services

[16] See, for example, HCFA *Report to Congress*, 10-2, 11-9; IOM 1996, 148 - 149, 153, and 395 - 397

[17] IOM 1996, 160

over the next six years.[18] In California there are 566 working nurses per 100,000 population, the lowest in the nation (the national average is 798/100,000).[19]

The current shortfall in active CNAs for available positions in California nursing homes is estimated at between 10,000 and 35,000, and the pool of active CNAs has declined from 120,000 in 1998 to 101,000 in 2000 (a drop of 15 percent). Further, the number of newly certified nurse assistants (25,388) is not keeping pace with the number of CNAs who are not renewing their certification (39,178).

Minimum nursing staff standards cannot achieve the goal of improving quality of nursing home care if facilities do not have access to an adequate labor pool. Expanding the nursing workforce requires coordinated strategies that address wages, working conditions, educational opportunities, career advancement opportunities, and personal preferences.

In addition, the nursing workforce shortage may contribute to high levels of turnover among nursing staff. When staff members are constantly changing, resident care in nursing home suffers in a number of ways. High turnover disrupts continuity of patient care, undermines employee morale, increases demands on remaining staff, and increases facility costs for employee recruitment and training.

Organizational Capacity

Organizational capacity generally refers to the management systems and practices that are necessary to operate a skilled nursing facility efficiently, consistent with whatever regulatory requirements are in place.

The December 2000 Institute of Medicine report*, Improving the Quality of Long Term Care*, asserts that:

> "Most nursing homes, even highly motivated ones, may lack the technical expertise and resources – including, but not limited to staffing levels – necessary to translate OBRA 87 regulations, practice guidelines, and quality improvement systems into practice…. Increasing staffing without simultaneously improving management systems will most certainly result in less-than-expected improvement."[20]

Nursing homes are highly complex organizations, providing housing, food services, personal care, social services, and medical care to very frail residents. Yet, leading

[18] California State University, University of California, California Community Colleges, and Association of Independent Colleges and Universities, *Educating California's Future Nursing Work Force Report*. As mandated by AB 655, Scott (Chapter 954, Statutes of 2000). (Sacramento: 2000), 5

[19] same as above

[20] IOM 2000, 11

researchers in the field of long term care have noted the lack of rigorous study regarding the basic systems and structures required to operate a nursing home efficiently. Such research is common in most other industrial and service enterprise.

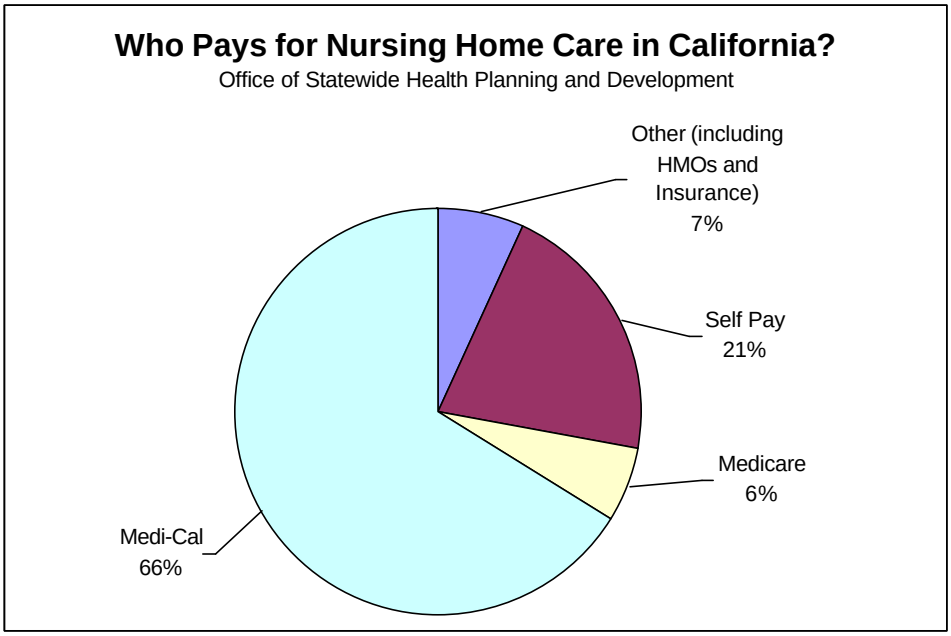
For example, restaurants have staffing models that enable them to calculate how many wait- and kitchen-staff will be necessary to ensure that in a lunch crowd of 100 diners an hour for two hours, with an L-shaped floor plan and twenty seat counter, and assuming that 20 percent of diners will place special orders, the average diner will wait no longer than fifteen minutes. The food service variables of a nursing home are even more complex, with some residents requiring assistance with eating, some preferring to be served in their rooms rather than the common dining area, and some requiring careful observation should problems such as choking arise.

Typically, such research and definition of standard practices should precede the determination of staffing resources required to implement the practices.

IV. FINANCIAL CONSIDERATIONS REGARDING NURSING STAFF STANDARDS

Staffing costs account for 54 percent of total freestanding skilled nursing facility costs.[21] Each one dollar increase in the average cost per patient day (now approximately $114) generates an industry-wide cost increase of approximately $36 million. Currently, the source of payment for 66 percent California's nursing homes residents is Medi-Cal. As shown in Figure 6, Medicare and insurance cover relatively small proportions of total skilled nursing residents, with private individuals paying the balance from their own resources.

Figure 6



Increasing minimum nursing staff requirements will have a significant impact on the state's budget and on the finances of private individuals.

A. Medi-Cal Fiscal Impact Estimates

Without considering any additional wage supplements that may be necessary for the recruitment and retention of new nurse staffing, the cost to Medi-Cal to reimburse each tenth of an hour of direct care above 3.2 for the current number of patient days would be

[21] Office of Statewide Health Planning and Development, *Aggregate Long-term Care Facility Financial Data for California Report Periods Ending December 31, 1997 – December 30, 1998* (Sacramento: OSHPD, 1999)

$39,501,720[22]. Table 2 summarizes the estimated fiscal impact of higher minimum nursing staff requirements, from 3.3 to 4.1 hours per patient day.

TABLE 2: ANNUAL COSTS IN TOTAL FUNDS FOR 0.1 HOURS PER PATIENT DAY INCREMENTAL INCREASES (IN THOUSANDS)

Required Staffing Hours	Medi-Cal Fee For Service (FFS)	Medi-Cal Managed Care	Medi-Cal Total	Industry Costs (Other Than Medi-Cal)	Total Industry Costs
3.3	$ 39,502	$ 7,474	$ 46,976	$ 21,270	$ 68,246
3.4	$ 79,003	$ 14,949	$ 93,952	$ 42,540	$ 136,492
3.5	$ 118,505	$ 22,423	$ 140,928	$ 63,810	$ 204,738
3.6	$ 158,007	$ 29,898	$ 187,905	$ 85,081	$ 272,986
3.7	$ 197,509	$ 37,372	$ 234,881	$ 106,351	$ 341,232
3.8	$ 237,010	$ 44,847	$ 281,857	$ 127,621	$ 409,478
3.9	$ 276,512	$ 52,321	$ 328,833	$ 148,891	$ 477,724
4.0	$ 316,014	$ 59,795	$ 375,809	$ 170,161	$ 545,970
4.1	$ 355,515	$ 67,270	$ 422,785	$ 191,431	$ 614,216

The estimates presented in the preceding table are based on the following data and projections: [23]

- Average hourly wages for direct care staff, 6/30/98 $9.92
  From Office of Statewide Health Planning and Development Aggregate Long-term Care Facility Financial Data for 12/31/97 to 12/30/98 Report periods ended.
- Updated 3.4% to 6/30/99 10.26
  Updated using labor index from 8/1/00 rate study.
- Updated 8% to 6/30/00 11.08
  Updated using 3% annual inflation factor plus 5% wage pass-through (WPT).
- Updated 12% to 1/31/02 12.41
  Updated using 3% annual inflation factor plus 7.5% WPT.
- Benefits computed at 30% of updated average hourly rate 3.72
- Estimated hourly salary, wage and benefits cost on 1/31/02 16.13
- Estimated cost for each 0.1 hour increase per patient day 1.613
- Medi-Cal patient days (including 1,416,155 days in distinct part SNFs) 24,489,597
  Days taken from 8/1/00 rate study budget sheet.

Additional Assumptions: a) all facilities are currently staffed at 3.2 hours per patient day; b) the current proportions of RNs to LVNs to CNAs would be retained; d) total

[22] From analysis prepared by Department of Health Services, Medi-Cal Policy Division, Medi-Cal Rate Development Branch, February 2001

[23] From analysis prepared by Department of Health Services, Medi-Cal Policy Division, Medi-Cal Rate Development Branch, February 2001

industry costs are extrapolated from the OSHPD calculation that approximately 66 percent of the total number of SNF patient days statewide are paid by Medi-Cal; d) inflation may understate current wage pressures in the industry; e) the larger the increase in required hours per patient day, the greater the wage pressures that will be experienced by the industry; and, f) the farther the hours per patient day are projected from the current ratio, the less reliable the estimate.

B. Financial Status of Skilled Nursing Facilities

A careful analysis of the impact of minimum staffing increases on skilled nursing facilities would require comparing current staffing levels with the new standard and estimating the cost of compliance, if any, for each. Such an analysis was not possible within the timeframe allowed for this report.

Further, the most current long-term care facility summary publications from the Office of Statewide Health Planning and Development reflect financial data for facilities whose fiscal years ended from 12/31/97 to 12/30/98. This period of time precedes the current 3.2 requirement by up to two years.

There are indications, however, that the industry as a whole is facing financial stress. For example, as of December 2000, six of the nation's largest nursing home chains had fallen into Chapter XI bankruptcy in the previous fifteen months.[24] Here in California, approximately 11 percent of nursing homes had filed for bankruptcy as of August 2000.

The financial stability of skilled nursing facilities is an important consideration. Resident care can be disrupted as a result of financial problems and facility closure requires that the residents be moved to another facility, which causes a great deal of stress for the residents and their families. With skilled nursing facilities operating at an average 88 percent occupancy rate, any significant reduction of available beds in a community reduces access to needed skilled nursing care for frail and chronically ill persons.

[24] "The year 2000: Record mergers, settlements and bankruptcies set the stage for 2001, "*Jenks Healthcare Business Report,* 11, No. 5 (2000): 1

V. CONCLUSIONS

During the last two years, Governor Davis has taken major steps in improving care in nursing homes by almost doubling the number of inspectors and strengthening enforcement when he proposed his Aging with Dignity Initiative and signed AB 1731 (Shelley.) Governor Davis has also provided significant increases in funding - to the tune of $470 million in the last two years – to help pay for improvements in the quality of care.

Minimum Staffing Requirement

The Department of Health Services recognizes the importance of adequate staffing to ensure quality of care. The recent increase in direct care hours to the current standard of 3.2 hours per patient day places California as the third highest in the nation -- exceeding both the "minimum" and "preferred minimum" staffing levels (2.75 and 3.0, respectively) discussed in HCFA's report, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Home.* Adequate empirical data is not available to support a conclusion that raising the minimum staffing requirement above the current standard will achieve a specific improvement in the quality of resident care. Therefore, without empirical data to guide this policy objective, an increase in the minimum nursing staff requirement at this time is not recommended.

Furthermore, assuring that individual residents receive sufficient nursing care to meet their needs requires a thorough understanding of the relationship between resident acuity and appropriate staffing levels. This relationship must be carefully examined prior to imposing additional staffing requirements and incurring additional significant cost.

Therefore, the Department of Health Services recommends reforming the way nursing homes are paid to improve accountability and quality of care while preserving reasonable cost controls. AB 1731 (Chapter 451, Statutes of 2000) directs DHS to review the current Medi-Cal reimbursement methodology and to examine several alternative models for a new Medi-Cal reimbursement system. The department recommends that this study be expanded to assess strategies for implementation of a facility-specific rate-setting system. This system should reflect the costs and staffing levels associated with quality of care for nursing home residents.

The department also recommends that future consideration be given to convert the current minimum standard of 3.2 nursing hours per patient per day to a staff-to-patient ratio in a manner that ensures flexibility in addressing individual patient needs.

To provide information with which to assist this examination, DHS will fund research recommended by the Institute of Medicine's report, *"Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?"* to examine the staffing time and mix required to

provide adequate processes and outcomes of care consistent with the needs and variability of residents.

Enforcement

Aggressive enforcement is necessary for a minimum nursing staff standard to be effective in protecting and promoting the quality of resident care.

Although there has been a marked increase in staffing levels during the past two years, approximately 33 percent of facilities sampled failed to meet the current minimum staffing standard of 3.2 nursing hours per patient per day. DHS intends to add a component to the standard federal nursing home survey protocol to calculate compliance with the 3.2 minimum standard. Approximately 25 percent of facilities surveyed will be subject to this calculation each year. Failure to comply with the minimum standard will result in a deficiency or a citation, if the violation meets the criteria established in statute.

Recruitment and Retention of Staff

The Governor's "Aging with Dignity" Initiative contains specific components to improve the quality of care by increasing access to an adequate labor pool and reducing high levels of staff turnover. For example, the Caregiver Initiative Grants were awarded to community groups to increase the number of direct care staff trained and to develop strategies for retention. A wage pass through was implemented to recognize direct care staff as well as dietary and housekeeping staff. A Quality Awards program, providing staff bonuses for exemplary facilities serving a high percentage of Medi-Cal residents, was enacted.

Currently, the Governor's Budget for 2001-02 proposes to add $5 million to the California Community Colleges for increasing the number of Industry Driven Regional Collaboratives to address the high demand for certain professionals, including nurses. The proposed budget also contains $10 million to the California State University systems to enhance the quality and number of graduates from various strategic academic programs, including nursing programs.

The Department of Health Services and the Department of Consumer Affairs are jointly sponsoring AB 1409 (Chan) which will, in part, encourage experienced nursing home administrators from other states to work in California nursing homes

These recent initiatives should be given an opportunity to be fully implemented and their impact evaluated in order to assure a comprehensive strategy for stimulating the development of an adequate labor pool.

The Department of Health Services also recognizes that fiscal incentives are among the strongest of incentives for change. While the wage pass-through proposals enacted in

1999 and 2000 were a valuable first step, the department recommends an additional initiative to develop and stabilize staffing in nursing facilities using financial incentives taking a slightly different approach. The department proposes a Medi-Cal rate increase to reward facilities that first increase salaries and benefits to workers through an enforceable binding agreement.

The Department also recommends extending the scope of the Innovative Facility Grants to include incentives for innovative recruitment and retention, and a renewal of the Caregiver Training Initiative for an additional year to further buttress the amount of staff available to meet CA's statutory minimum staffing requirements.

Recruiting, retaining and recognizing the professional contributions of these dedicated staff is essential to providing quality of care.

Appendix A

Terms and definitions

The following terms and definitions are intended to offer clarification and serve as a reference guide for many of the terms used in this report or terms that are commonly used in discussions of the report's subject matter.

Certification requirements: To receive reimbursement for the care provided to Medi-Cal or Medicare patients, health facilities must gain federal certification. Certification requirements are defined by federal law, regulation and policy, and occasionally by state law, regulation, or policy, when the federal requirement is that the state requirement be met.

Certified nursing assistant: In California, to gain certification as a nursing assistant, an applicant must complete 160 hours of training and pass a competency test and background clearance. Under the supervision of a licensed nurse (registered or vocational), a certified nursing assistant (CNA) provides basic nursing services to ensure the safety, comfort, personal hygiene, and protection of patients/residents in a licensed long-term or intermediate health care facility. CNAs may not perform any nursing services that require a professional nursing license. To gain certification, CNAs are sometimes referred to as "nursing assistants" or "nurse aides."

Federal deficiencies: When a facility is found to be out of compliance with a certification requirement, it is issued a federal deficiency that is graded on the basis of the scope and severity of the violation. For example, if the violation poses a potential for more than minimal harm to several patients, it would be graded at a lesser scope and severity than a violation that poses immediate jeopardy to most of the patients' health or safety. (The least severe scope and severity is graded at "A.") Facilities must provide a plan of correction for any deficiency of "B" or more, and at "D" or greater, additional remedies are applied. For "J" or more, the remedy may include temporary management or termination.

Intermediate care facility: "Intermediate care facility" (ICF) is the legal term for a facility that is licensed and/or certified to provide skilled nursing care and supportive care to patients who have need of those services but do not require continuous nursing care. (Skilled nursing facilities provide a higher level of care.) ICFs that care primarily for the elderly or otherwise unspecialized convalescent patients are also sometimes called "nursing facilities," or NFs.

Licensed nurses: In general, this term applies to both registered nurses (RNs) and licensed vocational nurses (LVNs) (or the LVN equivalent, which in many states goes by the title "licensed practical nurse"). This term may be used interchangeably with "professional nurses."

Licensed vocational nurse: In California, a licensed vocational nurse (LVN) is one who has been licensed by the California Board of Vocational and Psychiatric Technicians. LVNs, under the direction of physicians and registered nurses, provide basic bedside care. They take vital signs, treat bedsores, prepare and give injections and enemas, apply dressings, give alcohol rubs and massages, apply ice packs and hot water bottles, and insert catheters. They may also evaluate residents' needs, develop care plans, and supervise the care provided by nursing aides.[25] LVN training is most typically a year in duration and conducted through a community college or adult vocational education program. All candidates must pass a licensure examination.

Licensing requirements: To operate a health facility in the state of California, it is necessary to obtain the appropriate license. Licensing requirements are defined by state law, regulation, or policy.

Long-term care facility: "Long-term care facility" can refer one of several different types of health care facilities, including most commonly skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and congregate living health facilities (CLHFs). In this report, the only long-term care facilities discussed at any length are SNFs.

Nurse staffing: See "Nursing staff"

Nursing facility: The federal regulatory use of the term "nursing facility" refers to an intermediate care facility (ICF). It is not uncommon to hear reference to a "SNF/NF" where "SNF" refers to a "skilled nursing facility" and "NF" refers to a "nursing facility." SNF/NFs are facilities that are licensed and certified to provide both skilled nursing facility care and intermediate care.

Nursing home: The term "nursing home" refers primarily to facilities that are licensed as free-standing skilled nursing facilities. Nursing homes are also commonly known as convalescent hospitals.

Nursing staff: "Nursing staff" and "nurse staffing" are sometimes used interchangeably to refer generically to all of the staff members of a nursing home or hospital who provide nursing services to patients. For the purposes of this report, the term refers exclusively to registered nurses, licensed vocational nurses, and certified nursing assistants.

Professional nurses: See "Licensed nurses"

Registered nurse: In California, a registered nurse (RN) is one who is licensed through the California Board of Registered Nursing. In addition to supervising licensed vocational nurses and nursing aides, RNs have the broadest scope of practice among nursing staff. They develop and manage care plans; assist physicians during treatments and examinations; administer medications; instruct patients and their families in proper care; and perform difficult procedures such as starting intravenous

[25] Bureau of Labor Statistics, U.S. Department of Labor. *Occupation Outlook Handbook, 2000-2001 Edition.*

fluids.[26] RN training can be accomplished in several ways, including through a four-year baccalaureate degree, a three-year hospital diploma program, or a two-year associate degree. All candidates, however, must pass the licensure examination.

Residents: The term "residents" refers to people residing and receiving care in a nursing home or skilled nursing facility. Because of the discussion of "hours per patient day," in this report the terms "residents" and "patients" have at times been used interchangeably.

Skilled nursing facility: "Skilled nursing facility" (SNF) is the legal term for a health facility that provides continuous skilled nursing care and supportive care to patients whose primary health care need is the availability of skilled nursing care on an extended basis. In this report, the term refers specifically to free-standing SNFs, meaning that the facility is licensed as a stand-alone facility. There are also distinct-part SNFs, which function as a wing or unit within another kind of licensed health facility, most commonly acute-care hospitals.

State citations: The Department of Health Services' Licensing and Certification Program is authorized under state law to assess penalties (citations) for violations of state licensing requirements (for nursing homes, the law allow federal certification violations to be cited as well). The penalties range from $25,000-$100,000 for violations that are deemed to be the direct cause of death, to $100-$1,000 for violations that have a direct or immediate relationship to the health, safety, or security of the patient, resident or client.

Surveys: The California Department of Health Services' Licensing and Certification Program determines the compliance of health facilities with the applicable licensing and certification requirements through unannounced team inspections called "surveys." There are several kinds of surveys, including initial certification or licensure surveys which are required before a facility can gain either a license to operate or certification for reimbursement; regular surveys conducted on periodic basis to evaluate compliance; and surveys conducted in response to a complaint investigation that finds cause for closer examination of a facility's practices. During the survey process, the survey team examines facility records; conducts staff and patient interviews; and makes careful observations of patient care, staff and management activities and interaction, and facility operations.

[26] Bureau of Labor Statistics, U.S. Department of Labor. *Occupation Outlook Handbook, 2000-2001 Edition.*

Appendix B

CALIFORNIA HEALTH AND SAFETY CODE, SECTION 1276.7

(SNF Nursing Staff Ratio Report Requirements)

1276.7. (a) (1) On or before May 1, 2001, the department shall determine the need, and provide subsequent recommendations, for any increase in the minimum number of nursing hours per patient day in skilled nursing facilities. The department shall analyze the relationship between staffing levels and quality of care in skilled nursing facilities. The analysis shall include, but not be limited to, all of the following:

(A) A determination of average staffing levels in this state.

(B) A review of facility expenditures on nursing staff, including salary, wages, and benefits.

(C) A review of other states' staffing requirements as relevant to this state.

(D) A review of available research and reports on the issue of staffing levels and quality of care.

(E) The number of Medi-Cal beds in a facility.

(F) The corporate status of the facility.

(G) Information on compliance with both state and federal standards.

(H) Work force availability trends.

(2) The department shall prepare a report on its analysis and recommendations and submit this report to the Legislature, including its recommendations for any staffing increases and proposed timeframes and costs for implementing any increase.

(b) It is the intent of the Legislature to establish sufficient staffing levels required to provide quality skilled nursing care. It is further the intent of the Legislature to increase the minimum number of direct care nursing hours per patient day in skilled nursing facilities to 3.5 hours by 2004 or to whatever staffing levels the department determines are required to provide California nursing home residents with a safe environment and quality skilled nursing care.

Appendix C

S T A K E H O L D E R S

The following organizations and/or individuals were invited to submit materials for consideration in the preparation of this report.

Assembly Member Elaine Alquist, former Chair of the Assembly Committee on Aging and Long-Term Care

American Association of Retired Persons – California Office and National Headquarters

American Federation of State, County, County and Municipal Employees

American Nurses Association, California

Asian Pacific Older Adults Task Force

Association of California Nurse Leaders

Barry Barken, Live Oak Living Center

Bet Tzedek Legal Services

Beverly Enterprises, Inc.

Board of Registered Nursing

Board of Vocational Nursing and Psychiatric Technicians

California Association for Nursing Home Reform

California Association of Health Facilities

California Association of Homes and Services for the Aged

California Association of Medical Directors

California Commission on Aging

California Department of Aging, Triple A Council of California

California Department of Corrections

California Department of Developmental Services

California Department of Health Services

Medi-Cal Office of Managed Care

Medi-Cal Policy Division, Rate Development

California Department of Mental Health, Long-Term Care Services

California Department of Veterans Affairs

California Health and Human Services Agency, Long Term Care Council

California Healthcare Association

California Licensed Vocational Nurses Association

California Mental Health Directors Association

California Nurses Association

California Nursing Outcome Coalition

California Office of Statewide Health Planning and Development

California Rehabilitation Association

Beth Capell, Capell and Associates

Deborah Cavallo, Eden Alternative™, Region 8

Center for Health Care Rights

Country Villa

Direct Care Alliance

Edward R. Roybal Institute for Applied Gerontology, College of Health and Human Services, California State University, Los Angeles

Jan Eisenbeis, Hunter Richey DiBenedetto Brewer LLP

Jeannine English, Robinson and Associates, Inc.

Guardian Health Group

Hacienda La Puente Adult Education Health Careers Department

Charlene Harrington, Department of Social and Behavioral Sciences, University of California, San Francisco

Harmony Skilled Network

Healthcare Financial Solutions

Institute for Health and Socio-Economic Policy

North American Health Care, Inc.

Lenox Healthcare

Little Hoover Commission

Robert Macaluso, Crestwood Behavioral Health, Inc.

Beth A. Mann, State Long-Term Care Ombudsman

Mariner Post-Acute Network

National Citizens Coalition of Nursing Home Reform

National Institute of Nursing Research

National Senior Citizens Law Center (Los Angeles and National Offices)

Senator Deborah Ortiz, Chair of the Senate Committee on Health and Human Services

Georgia Otterson, Creekside Convalescent Hospital

School of Public Policy and Social Research, University of California, Los Angeles

Senior Care Network of Huntington Memorial Hospital

Services Employees International Union, California State Council, Western Regional Office

Assembly Member Kevin Shelley, Assembly Majority Leader and Author of AB 1731

Mary Suilmann, Telecare Corporation

Sun Healthcare Group, Inc.

Assembly Member Helen Thompson, Chair of the Assembly Committee on Health

United Nurses Association of California

University of California, Office of the President

Senator John Vasconcellos, Chair of the Senate Sub-Committee on Aging and Long-Term Care

Vencor, Inc.

Yvonne Wood, Garfield Neurobehavior Center

Appendix D

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Appendix E

OTHER STATES' REQUIREMENTS FOR MINIMUM NURSING STAFF IN NURSING HOMES

To compile this appendix, the Department of Health Services used the National Citizens' Coalition for Nursing Home Reform Report titled, *Federal and State Minimum Staffing Requirements*, and then contacted each state for any clarification or update.

KEY:	RN	Registered Nurse	LPN	Licensed Practical Nurse (same as LVN)	CNA	Certified Nursing Assistant (same as NA)
	DON	Director of Nursing	LVN	Licensed Vocational Nurse (same as LPN)	NA	Nursing Assistant (same as CNA)
	FT	Full-time	MD	Medical Director	SNF	Skilled Nursing Facility
	NF	Nursing Facility	ICF	Intermediate Care Facility		

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Alabama	No additional state minimum staffing requirement. Follows federal rule.		
Alaska	Regulation [07 AAC 012.275]	• A nursing facility must have an RN on duty 7 days/week day shift, 5 days/week evening shift. An LPN must be on duty during all shifts when an RN is not present. • Facilities with less than 60 occupied beds must have 2 RNs during day shift, 1 RN other shifts.	No nursing waivers.
Arizona	No additional state minimum staffing requirement. Follows federal rule.		

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Arkansas	Staffing legislation passed in 1998 - Act 1529. • **By June 30, 2000** nursing homes were required to maintain the following ratios: CNAs: 1:8 Day Shift 1:12 Evening Shift 1:18 Night Shift Licensed Personnel (RN, LPN, LVN): 1:30 Day Shift 1:30 Evening Shift 1:50 Night Shift • **By September 30, 2000**, nursing homes were required to maintain the following ratios: CNAs: 1:7 Day Shift 1:12 Evening Shift 1:18 Night Shift Licensed Personnel (RN, LPN, LVN): 1:15 Day Shift 1:15 Evening Shift 1:35 Night Shift	• Facilities containing 70 or more beds must employ an RN supervisor during the day and evening shifts in addition to the previous requirements. • Facilities containing 100 or more beds must, in addition to the above requirements, employ an RN supervisor during the night shift; employ a full-time assistant director of nursing (DON); and employ a full-time RN director of in service education.	• No nursing waivers. • Individuals employed to provide services such as food preparation, housekeeping, laundry or maintenance services shall not be counted in determining the above staffing ratios. • Nursing homes must post on each hall, wing, or corridor the number of licensed and unlicensed personnel on duty at each shift. The posting will consist of a sign-in sheet where the staff member must sign in upon arrival and again upon departure. The current number of residents on that unit shall also be posted at the same place as the staffing report. This information must be posted in a conspicuous place and in a manner which is visible and accessible to all residents, families, and visitors.
Colorado	Code of Colorado Regulations 1011, Chapter 5, Part 7. Nursing care facility must provide nurse staffing sufficient in number to provide at least 2.0 hours of nursing time per resident per day.	• Nursing care facility: at least one RN must be on duty (and on the premises) at all times [except as provided under section 7.6]. • Each resident care unit must be staffed with at least a licensed nurse. • Intermediate care facility: at least one RN or LPN must be on duty (and on the premises) on the day shift 7 days/week. Facility may use LPN as DON. • Nursing facility required to employ a full-time DON who is an RN and qualified by education and experience to direct facility-nursing care.	• Waivers of the RN requirement may be granted if: ✓ facility is located in a rural area; the ✓ facility has at least one FT RN who is regularly on duty; ✓ facility has only residents whose attending physicians have indicated that each resident does not require the services of an RN for a 48-hour period or the facility has made arrangements for a professional nurse or physician to be on-site as necessary to provide needed services when the regular FT RN is not on duty; and ✓ facility has made a good faith effort to comply with the RN requirement but RNs are unavailable in the area. • If 60+ residents, the time of the DON, Staff development Coordinator, and other supervisory personnel who are not providing direct resident care may not be used in computing this ratio.

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Connecticut	Connecticut Public Health Code Sec. 19-13-D8t • Minimum staffing for chronic and convalescent nursing home: *Licensed nursing personnel* 7 am - 9 pm = .47 hours/patient 9 pm - 7 am = .17 hours/patient *Total nursing & nurse's aide personnel* 7 am - 9 pm = 1.40 hours/patient 9 pm - 7 am = .50 hours/patient • Minimum staffing for a rest home with nursing supervision staff: *Licensed nursing personnel* 7 am - 9 pm = .23 hours/patient 9 pm - 7 am = .08 hours/patient *Total nursing & nurse's aide personnel* 7 am - 9 pm = .70 hours/patient 9 pm - 7 am = .17 hours/patient	• There shall be at least one RN on duty 24-hours/day, 7 days/week • In a chronic and convalescent nursing home, there must be at least one licensed nurse on duty on each patient occupied floor at all times. • In a rest home with nursing supervision, there must be at least one nurse's aide on duty on each patient occupied floor at all times and intercom communication with a licensed nurse.	• No nursing waivers. • In facilities of 61+ beds, the DON shall not be included in the above requirements. • In facilities of 121+ beds, the DON shall not be included in the above requirements.
Delaware	**Passed May of 2000** Must provide 3.25 hours of direct nursing care per 24-hour period.		
District of Columbia	No additional state minimum staffing requirement. Follows federal rule.		
Florida	Title 59A-4 Florida Administrative Code. • At a minimum, the facility will staff an average of 2.0 hours of certified nursing assistant and .75 hours of licensed nursing and .20 hours RN staff time for each resident during a 24-hour period. • The DON shall designate one licensed nurse on each shift to be responsible for the delivery of nursing services during that shift. • In a multi-story, multi-wing, or multi-station facility, there shall be a minimum of one nursing services staff person who is capable of providing direct care on duty at all times on each floor, wing, or station. Note: In 1999, the Florida legislature passed legislation giving nursing homes $40 million to increase staffing and CNA wages, but it did not legislatively require specific staffing ratios.	• When a DON is delegated institutional responsibilities, a full-time qualified RN must be designated to serve as Assistant DON. • Facilities with a census of 121 or more residents must designate an RN as an Assistant DON.	No nursing waivers.

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Georgia	Georgia DHR Rules, chapter 290-5-8-.04. • A minimum of 2.0 hours of direct nursing care per patient in a 24-hour period. • For every 7 total nursing personnel required, there shall not be less than one RN or LPN. • Nursing staff shall be employed for nursing duties only. • Medicaid policy • Level I and Level II nursing facilities are required to provide a minimum of 2.5 nursing hours per patient day.	• There must be at least one nurse, registered, licensed undergraduate, or licensed practical on duty and in charge of all nursing activities during each 8-hour shift. • An RN shall be employed full-time as DON. She/he may not also be the administrator.	No nursing waivers.
Hawaii	Department of Health regulations, 11-94-23.	• Skilled Nursing Facility -- at least one RN, full-time, 24-hours/day, 7 days/week. • Intermediate Care Facility -- at least one RN, full-time, on day shift and at least one licensed nurse whenever medications are administered.	
Idaho	IDAPA 16.03.02200,02. • Skilled Nursing Facilities: ✓ 59 or less residents -- 2.4 hours/resident/day. Hours shall not include DON but may include the supervising nurse on each shift. ✓ 60+ residents -- 2.4 hours/resident/day. Hours shall not include the DON or supervising nurse. • Nursing Facilities: ✓ 1.8 hours/resident/day. Hours may include the DON, supervising nurse and charge nurses. • SNFs & NFs shall be considered in compliance with the minimum staffing ratios if, on Monday of each week, the total hours worked by nursing personnel for the previous 7 days equal or exceed the minimum staffing ratio for the same period when averaged on a daily basis and the facility has received prior approval from the Licensing Agency to calculate nursing hours in this manner.	• In facilities with 60+ residents, the DON shall have strictly nursing administrative duties • In facilities with 59 or less residents the DON may, in addition to administrative responsibilities, serve as the supervising nurse. SNFs with 60+ residents: • an RN shall be on duty 8 hours each day and no less than an LPN shall be on duty for each of the other 2 shifts. • SNFs with 60 - 89 residents. • an RN shall be on duty during the day shift and the evening shift and no less than an LPN shall be on duty during the night shift. SNFs with 90+ residents: • an RN must be on duty at all times. ICFs: • an RN or LPN must be on duty at all times as charge nurse. • if an LPN is charge nurse, the facility must make documented arrangements for an RN to be on call for these shifts to provide professional nursing support.	• Regulation permits waiver of RN as Supervising or Charge Nurse if a facility is unable to hire an RN to meet the requirements so long as: the facility continues to seek an RN at a compensation level at least equal to prevailing community rates; documented record of efforts to secure RN personnel is maintained in the facility; and the facility maintains at least 40 hours/week RN coverage.

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Illinois	77 Illinois Administrative Code Chapter I, sec. 300.1230. • Skilled Nursing Care = at least 2.5 hours of nursing care each day, of which at least 20% must be licensed nurse time. • Intermediate Care = at least 1.7 hours of nursing care each day, of which at least 20% must be licensed nurse time. • Light intermediate care shall be provided with at least 1 hour of nursing care each day, of which at least 20% must be licensed nurse time. • A resident needing light intermediate care is one who needs personal care as defined in section 1-120 of the Act; is mobile; requires some nursing services; needs a program of social services and activities directed toward independence in daily living skills; and needs daily monitoring. • At least 40% of the minimum required hours shall be on the day shift; at least 25% on the evening shift; and at least 15% on the night shift.	• A licensed nurse must be designated as a charge nurse when neither the DON nor Assistant DON is on duty. If both RNs and LPNs are on duty, this person shall be an RN. • SNFs = at least one RN must be on duty 8 consecutive hours, 7 days/week. • There shall be at least one RN or LPN on duty at all times in an ICF or a SNF.	• Give nursing waivers. • The DONs time shall not be included in staffing ratios.
Indiana	410 IAC 16.2-3.1-17. Except when waived, facility shall provide a licensed nurse hour to resident ratio of 0.5 licensed nurse hour per resident day, averaged over a one-week period.	• Facility must designate a licensed nurse to serve as charge nurse on each tour of duty. • Facility must have an RN on duty for at least 8 consecutive hours/day, 7 days a week. • DON may serve as charge nurse only when facility daily occupancy is fewer than 60 residents. These hours may be counted toward the staffing requirement.	Give nursing waivers, if: • Facility demonstrates it was unable to recruit proper personnel . • A waiver would not endanger the health or safety of the residents. • An RN or physician is on call at all times and required to respond immediately to calls • State agency provides notice to the LTC Ombudsman and the protection and advocacy system.

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Iowa	IAC 58.11(2). • The minimum hours of resident care personnel required for residents needing intermediate nursing care shall be 2.0 hours/resident/day computed on a 7-day week. A minimum of 20% of this time shall be provided by qualified nurses. • If the maximum medical assistance rate is reduced below the 74th percentile, the requirement will return to 1.7 hours/resident/day computed on a 7-day week. • A minimum of 20% of this time shall be provided by qualified nurses. • The minimum hours of professional nursing personnel for residents requiring skilled nursing care shall be 168 hours/week for facilities under 50 beds. For every additional bed over 50, 2.24-hours of additional nursing/ week is required. • Non professional nursing care staff shall be required in the ratio of 0.28 employee/bed/per week.	• An ICF with 75+ beds must have a qualified nurse on duty, 24-hours/day, 7 days/week. • An ICF with less than 75 beds that employs an LPN as a health service supervisor must also employ an RN for at least 4 hours each week for consultation. The RN must be on duty at the same time as the supervisor. • Facilities with 75+ beds must employ a health services supervisor who is a registered nurse. • A SNF must provide 24-hour service by licensed nurses, including at least one registered nurse on the day shift, 7 days/week. • The health service supervisor must not serve as the charge nurse in a SNF with 60 + residents.	• The health supervisor's hours worked per week shall be included in computing the 20% requirement.
Kansas	Kansas Administrative Regulations, 28-39-154. • Per facility, there shall be a weekly average of 2.0 hours of direct care staff time per resident and a daily average of not fewer than 1.85 hours during any 24-hour period. • The ratio of nursing personnel to residents per nursing unit shall not be fewer than one nursing staff member for each 30 residents or for each fraction of that number of residents. • A licensed nurse shall be on duty 24-hours/day, seven days/week. An RN must be on duty at least 8 consecutive hours/day, 7 days/week. • On the day shift there shall be the same number of licensed nurses on duty as there are nursing units.		• The DON shall not be included in the weekly and daily average computation in facilities with less than 60 beds. • However, the DON may be counted to meet the licensed nurse on duty requirement.

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Kentucky	No minimum staffing standard exists in Kentucky. The Licensing Agency provided the following clarification: The Division of Licensing and Regulation has followed the lead of the Federal Government in that the licensing regulations reflect the certification regulations regarding minimum staffing requirements. The reasons are as follows: • Often when minimum staff requirements are established, the minimum then becomes the maximum; • Acuity levels of residents may change on a daily basis, and thus it would not be possible to predict what staffing ratios are necessary; and • Minimum staff ratios would hamper our ability to utilize an outcome based survey process as well as providing a defense for nursing homes to employ anytime a deficiency is cited related to "understaffing."		
Louisiana	Louisiana Licensure Standards, sec. 9811. • As a minimum, the nursing home shall provide 1.5 hours of care per resident each day. • Nursing homes participating in Medicaid shall be required to meet the following standards for payment for nursing home services in addition to the standards currently in effect: ✓ The ratio of nursing care hours to residents shall be 2:35 on intermediate care level residents. ✓ The ratio of nursing care hours to residents shall be 2:60 on skilled level residents.	• Licensed nurse coverage must be provided 24-hours/day. • The DON may serve as charge nurse only when 60 or fewer residents. • Nursing homes with a census of 101 + must have an assistant DON who shall be an RN unless written waiver is received from the Department of Health.	• Waiver permitted if facility is unable to obtain 7-day RN coverage. Request for waiver must include proof that diligent efforts have been made to recruit appropriate personnel, and names and phone numbers of RNs interviewed for the job. Louisiana also follows federal waiver provisions, contained in the Nursing Home Reform Act of 1987.

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Maine	10-144 CMR 110, Chapter 9. • Day shift = 1:8 • Evening shift = 1:12 • Night shift = 1:20	An RN must be on duty for at least 8 consecutive hours each day of the week. Day Shift: • A licensed nurse must be on duty 7 days/week. • An RN must be designated as the charge nurse -- in facilities with less than 20 beds, the DON may also be the charge nurse. • An additional licensed nurse must be added for each 50 beds above 50. • In facilities with 100+ beds, the additional licensed nurse must be an RN for each multiple of 100 beds. Evening Shift: • A licensed nurse must be on duty 8 hours each evening. • An additional licensed nurse shall be added for each 70 beds. • In facilities with 100+ beds, one of the additional licensed nurses must be an RN. Night Shift • A licensed nurse must be on duty 8 hours each evening. • An additional licensed nurse shall be added for each 100 beds. • In facilities with 100+ beds, an RN must be on duty.	• Nurse aides in training may not be counted in the ratio. • Private duty nurses shall have no effect on the nursing staff requirements. • Sharing of nursing staff is permitted between the nursing facility and other levels of assisted living on the same premises as long as there is a clear documented audit trail and the staffing in the nursing facilities remains adequate to meet the needs of residents.
Maryland	Code of Maryland Regulations, 10.07.02. • Comprehensive care facilities shall employ supervisory personnel and a sufficient number of supportive personnel to provide a minimum of 2 hours of bedside care per licensed bed per day, 7 days/week. • Comprehensive care facilities shall provide at least the following supervisory personnel: 2-99 residents = 1 FT RN. 100-199 residents = 2 FT RNs. 200-299 residents = 3 FT RNs. 300-399 residents = 4 FT RNs. • The ratio of nursing service personnel on duty to patients may not at any time be less than 1:25 or fraction thereof.	Extended care facilities shall be staffed with an RN 24-hours/day, 7 days/week.	• Facilities with 40 or fewer beds, which do not participate in a federal program, may request an exception to the indicated staffing pattern. • Bedside hours include the care provided by RNs, LPNs, and supportive personnel, except that ward clerk's time shall be computed at 50% of the time provided on the nursing unit. • Only those hours which the director of nursing spends in bedside care may be counted in the 2 hour minimal requirement.

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Massachu-setts	105 CMR 150.007. • Level I care shall provide, at a minimum, a total of 2.6 hours of nursing care/patient/day; at least 0.6 hours shall be provided by licensed nursing personnel and 2.0 hours by ancillary nursing personnel. • Level II care shall provide, at a minimum, a total of 2.0 hours of nursing care/patient/day; at least 0.6 hours shall be provided by licensed nursing personnel and 1.4 hours by ancillary nursing personnel. • Level III care shall provide, at a minimum, a total of 1.4 hours of nursing care/patient/day; at least 0.4 hours shall be provided by licensed nursing personnel and 1.0 hours by ancillary nursing personnel. • Level IV care shall provide: ✓ Facilities with less than 20 beds -- at least one "responsible person" on active duty during waking hours in the ratio of 1:10 residents. ✓ Facilities with more than 20 beds -- at least one "responsible person" on active duty at all times, 24-hours/day, 7 days/ week, per unit. ✓ If none of the responsible persons on duty are licensed nurses, then the facility shall provide a licensed consultant nurse, 4 hours/month, per unit.		• The supervisor of nurses and the charge nurse, but not the DON, may be counted in the calculation of licensed nursing personnel. • The amount of nursing care time per patient shall be exclusive of non-nursing duties.
Michigan	Michigan Compiled Laws Michigan Department of Public Health Rules sec. 333.21720a. • A nursing home shall maintain staff sufficient to provide not less than 2.25 hours of nursing care/ resident/day. • The ratio of residents to nursing care personnel: ✓ Morning shift = 1:8 ✓ Afternoon shift = 1:12; and ✓ Nighttime shift = 1:15	• Each nursing home must have an RN employed full-time as DON. • There must be an RN on duty at least 8 consecutive hours/day, 7 days/week. • Each nursing home must have a licensed nurse on each shift to serve as charge nurse.	• In a nursing home having 30 or more beds, the director of nursing shall not be included in counting the minimum ratios of nursing personnel. • An employee designated as nursing staff shall not be engaged in providing basic services such as food preparation, housekeeping, laundry, or maintenance services.

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Minnesota	Minnesota Statutes Annotated sec. 144A.04 Minnesota Rules sec. 4658.0510. • The minimum number of hours of nursing personnel to be provided in a nursing home is the greater of 2.0 hours/resident/24-hours or 0.95 hours per standardized resident day. • Regulations require that the minimum number of hours of nursing personnel to be provided is: ✓ 2.0 hours of nursing personnel/resident/24-hours (for nursing homes not certified to participate in medical assistance) ✓ The greater of 2.0 hours/resident/24-hours or 0.95 hours per standardized resident day (for nursing homes certified to participate in the medical assistance program).	• A nursing home must have a full time DON who is an RN and is assigned full time to the nursing services of the facility. • A nurse must be employed so that on-site nursing coverage is provided 8 hours/day, 7 days/week.	• The non-productive hours of the in-service training director are not included in the above standard. • In homes with more than 60 licensed beds, the hours of the DON are excluded. • "Hours of Nursing Personnel" means the paid, on-duty, productive nursing hours of all nurses and nursing assistants, calculated on the basis of any given 24-hour period.
Mississippi	Mississippi Code Annotated, 43-11-201.1. • Previously 2.33 hours per patient day. Regulation effective January 2000, requirement increased to 2.67 hours/patient/day.	• RN coverage on the day shift 7 days/week. • Facilities with 180+ beds shall have an assistant DON, who shall be an RN. • In facilities with 60 beds or less, the DON may serve as the charge nurse. In facilities with 60+ beds, the DON may not serve as charge nurse, or as medication/treatment nurse.	
Missouri	No additional state minimum staffing requirement. Follows federal rule. State standard repealed in 1998.		
Montana	• **Day shift must have:** ✓ 8 RN hours for 90 beds or less. ✓ 16 RN hours for 91 plus beds ✓ 8 LPN hours for 41-75 beds ✓ 16 LPN hours for 76 plus beds • **Evening shift must have:** ✓ 8 LPN hours for 50 beds or less ✓ 8 RN hours for 51 beds or more ✓ 8 LPN hours for 76 beds or more • **Night Shift:** ✓ 8 LPN hours for 70 beds or less ✓ 8 RN hours for 71 plus beds ✓ 8 LPN hours for 81 Plus beds		• Direct care does not include DON Coordinator; Patient Care Coordinator; Staff Development Coordinator; Ward Clerk; Medical Records Coordinator; Administrative Aide in-training; Orientees; Restorative Aides employed by Therapist; Volunteers; any RNs, LPNs or charge nurses classified as any of the above.
Nebraska	No additional state minimum staffing requirement. Follows federal rule.		

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Nevada	Nevada Medicaid Services Manual, sec. 502.3. Based on acuity of care needs, Medicaid program audits and reimburses SNFs to provide the following minimum-maximum hours per patient day: • Skilled Nursing Level 3 6.00 – 10.75 • Skilled Nursing Level 2 4.00 - 5.75 • Skilled Nursing Level 1 3.00 - 3.75 • Intermediate Care Level 3 2.50 - 2.75 • Intermediate Care Level 2 1.50 - 1.75 • Intermediate Care Level 1 0.75 - 1.00		• Direct care does not include: DON; Assistant DON; In-service Coordinator; Patient Care Coordinator; Staff Development Coordinator; Ward Clerk; Medical Records Coordinator; Administrative Aide in-training; Orientees; Restorative Aides employed by Therapist; Volunteers; any RNs, LPNs or charge nurses classified as any of the above.
New Hampshire	No additional state minimum staffing requirement. Follows federal rule.		
New Jersey	NJAC 8:39-25.1 through 25.4. RNs, LPNs, and NAs shall spend the following amounts of time on professional duties: • Total number of residents multiplied by 2.5 hours/day; plus • Total number of residents receiving each service listed below, multiplied by the corresponding number of hours/day: ✓ Tracheostomy: 1.25 hours/day ✓ Use of respirator: 1.25 hours/day ✓ Head trauma stimulation/Advanced neuromuscular/Orthopedic care 1.50 hours/day ✓ Intravenous therapy: 1.50 hours/day ✓ Wound care: 0.75 hours/day ✓ Oxygen therapy: 0.75 hours/day ✓ Nasogastric tube feedings and/or Gastrostomy:1.00 hours/day There shall be a visual observation by a member of the resident care staff of each resident at least once per hour. These observations need not be documented.	• At least 20% of the hours of care required shall be provided by RNs or LPNs. • An RN shall be on duty at all times in facilities with 150+ beds. • Facilities with 150+ beds shall have an assistant DON who is an RN. • There shall be at least one RN on duty in the facility during the day shift.	
New Mexico	No additional state minimum staffing requirement. Follows federal rule.		
New York	No additional state minimum staffing requirement. Follows federal rule.		

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
North Carolina	North Carolina Administrative Code, Title 10, 03H.2303. • Except for designated units with higher staffing requirements noted elsewhere in the subchapter, daily direct patient care nursing staff, licensed and unlicensed, shall equal or exceed 2.1 nursing hours per patient day. Inclusive in these nursing hours is the requirement that at least one licensed nurse is on duty for direct patient care at all times. Note: North Carolina regulations also contain staffing standards for adult care homes. And, legislation to improve staffing ratios for adult care homes was introduced in 1997 in the General Assembly.	• An RN shall be designated to serve as the DON on a full time basis. • The DON shall serve as the charge nurse only if occupancy is less than 60.	• Staffing waivers granted by the federal government for Medicare and Medicaid certified beds shall be accepted for licensure purposes.
North Dakota	No additional state minimum staffing requirement. Follows federal rule.		

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Ohio	ORC 3701-17-08. • Each nursing home shall have at least one attendant on duty at all times for each 15 residents and one other person on duty at all times; • at least one person working 40 hours/week for each 4 residents; • and the following minimum nurse staffing which may be counted in determining the foregoing personnel requirements: • 10 or fewer residents = 1 nurse on duty at least 8 hours/day between 6 am and 5 pm and a nurse on call at all other times. • 11- 25 residents = 1 nurse on duty at least 16 hours/day between 6 am and 12 midnight and a nurse on call at all other times. • 26 - 50 residents = 1 nurse on duty at all times. • 51 - 75 residents = 2 nurses on duty at all times; provided, at least one nurse shall be an RN on duty not less than 8 hours between 6 am and 5 pm. • 76 - 100 residents = at least 2 nurses; an RN shall be on duty not less than 8 hours each day between 6 am and 5 pm. • 100+ residents = an RN on duty at all times and an additional nurse on duty at all times for every 50 residents		• Give nursing waivers, if: ✓ Facility has made diligent efforts to recruit the required personnel. ✓ Facility is offering the prevailing wage for RNs and LPNs. ✓ Facility and personnel policies are such as to offer satisfactory working conditions to prospective employees.
Oklahoma	Oklahoma Regulations 310:675-13-12. • Day Shift = 1:10 • Evening Shift = 1:15 • Night Shift = 1:20	• A licensed nurse shall be on duty 8 hours/day, 7 days/week on the day shift. • If the DON is an LPN, an RN shall be employed for at least 8 hours/week as a consultant.	• Give nursing home waivers

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Oregon	Oregon Administrative Rules 411-86-100 • Day Shift = 1:10 • Evening Shift = 1:15 • Night Shift = 1:25	• Licensed nurse hours shall include no less than 1 RN/resident/week. • The facility shall have a licensed charge nurse on each shift, 24-hours/day. The charge nurse must be an RN for no less than 8 consecutive hours between 7 am and 11 pm, 7 days/week. • The DON may serve as charge nurse only when the facility has 60 or fewer residents.	• Give nursing waivers • No more than 25% of the nursing assistants assigned to residents pursuant to the above ratio may be nursing assistants who are not yet certified. • When an RN serves in the temporary absence of the administrator, his/her hours shall not be used to meet minimum nursing hours. • In facilities with 41+ beds, the hours of a licensed nurse who serves as facility administrator shall not be included in any licensed nurse coverage.
Pennsylvania	Pennsylvania Administrative Code, title 28, chapter 211 • Total number of hours of general nursing care in each 24-hour period shall be a minimum of 2.7 hours for each skilled patient and 2.3 hours for each intermediate care patient.	• Day shift must have: ✓ 1 RN for 59 beds and under, ✓ 1 RN for 60-150 beds, ✓ 1 RN & 1 LPN for 151-250 beds, ✓ 2 RNs for 251-500 beds, ✓ 4 RNs for 501-1000 beds • **Evening Shift must have:** ✓ 1 RN for 59 beds and under, ✓ 1 RN for 60-150 beds, ✓ 1 RN & 1 LPN for 151-250 beds, ✓ 2 RNs for 251-500 beds, ✓ 3 RNs for 501-1000 beds. • **Night Shift:** ✓ 1 RN or 1 LPN for 59 beds and under, ✓ 1 RN for 60-150 beds, ✓ 1 RN & 1 LPN for 151-250 beds, ✓ 2 RNs for 251-500 beds, ✓ 3 RNs for 501-1000 beds. • There shall be a full time DON who shall be a qualified RN. • The DON may also serve as the day professional staff nurse in a facility with an average daily census of 59 patients or less.	
Rhode Island	No additional state minimum staffing requirement. Follows federal rule.		

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
South Carolina	South Carolina State Law. SC Department of Health & Environmental Control Regulation 61-17. • Recently passed legislation requires: • In addition to the number of licensed nursing personnel required by regulation, a nursing home must provide at a minimum the following resident-staff ratios: ✓ 9:1 for shift 1 ✓ 13:1 for shift 2 ✓ 22:1 for shift 3	Regulation states: • The required minimum number of licensed nurses for any nursing station which serves at least 1 resident is one per station per shift. If a nursing station serves more than 44 residents, then that station is required to have 2 licensed nurses on all shifts. • The facility shall designate an RN as a full time DON.	
South Dakota	No additional state minimum staffing requirement. Follows federal rule.		
Tennessee	Tennessee Code, Chapter 1200-8-6-.04 • A minimum of 2.0 hours of direct care to each resident every day, including 0.4 hours of licensed nursing personnel time. • The number of direct nursing hours required shall be calculated according to the following formula: ✓ # residents x # nursing hours required/ resident day = total direct nursing hours required ✓ # residents x # licensed nursing hours required/resident day = total licensed nursing hours required ✓ Divide the total hours required by the number of hours worked by a full-time person	• At least 1 licensed nurse on duty at all times. • If the nursing service is under the direction of an LPN, an RN must be available on the nursing home premises to consult, review, and advise on the quality of nursing care for at least 48 weeks in each calendar year. The RN consultant must be on the premises at least 8 hours each week (12 hours/week in homes with 51+ beds). • In facilities with 50 beds or less, the DON, in addition to nursing administrative and supervisory responsibilities, may participate in general nursing duties and patient care activities not to exceed 50% of his/her working hours.	
Texas	Texas Administrative Code, Title 25, Part I, Chapter 145. Texas Dept of Human Services, sec. 19.1001,2.	• At a minimum, the facility must maintain a ratio of 1 licensed nursing staff person for each 20 residents or a minimum of 0.4 licensed-care hours/resident day. • The facility must designate an RN to serve as DON on a full-time basis. • There must be a licensed nurse to serve as charge nurse on each tour of duty. • Facility must use the services of an RN for at least 8 consecutive hours/day, 7 days/week.	• Give nursing waivers • Licensed nurses who may be counted include, but are not limited to, DON, Assistant DON, Staff Development Coordinators, Charge Nurses, and Medication/Treatment Nurses. • Staff, who also have administrative duties not related to nursing, may be counted in the standard only to the degree of hours spent in nursing related duties.
Utah	No additional state minimum staffing requirement. Follows federal rule.		

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
Vermont	No additional state minimum staffing requirement. Follows federal rule.		
Virginia	No additional state minimum staffing requirement. Follows federal rule.		
Washington	Washington Administrative Code Title 388-97-115. • Skilled Care = 2.25 hours/patient/day • Intermediate Care = 2.00 hours/patient/day • Limited nursing care = 1.25 hours/patient/day • A minimum of 20% of the above hours/patient/day must be provided by nurses.	• The nursing home shall have an RN on duty directly supervising resident care a minimum of 16 hours/day, 7 days/week. • An RN or LPN must be on duty directly supervising resident care the remaining 8 hours/day. • The nursing home shall designate an RN or LPN to serve as charge nurse and shall have a full time DON who is an RN. • An intermediate care facility with: ✓ Fewer than 60 residents shall have at least 1 RN or 1 LPN on duty during every daytime tour of duty. The RN may be the DON. ✓ 60 or more residents shall have at least 1 RN on duty during every daytime tour of duty. The RN may be the DON in accordance with paragraph (a). • A SNF shall have at least 1 charge nurse on duty at all times, and: ✓ If fewer than 60 residents -- at least 1 RN who may be the DON on duty as charge nurse during daytime ✓ If 60 - 74 residents -- in addition to the DON, at least 1 RN on duty as charge nurse during daytime ✓ If 75 - 99 residents -- in addition to the DON, at least 1 RN on duty as charge nurse during daytime and at least 1 RN on duty as charge nurse on a non-daytime tour of duty ✓ If 100+ residents -- in addition to the DON, at least 1 RN on duty as charge nurse at all times. • An intermediate care facility shall have a charge nurse during every daytime tour of duty, who may be the DON.	

State	Standard	Professional Nurse Coverage	Other: Nursing Waivers, Staff Counted in Standard, Staffing Disclosure
West Virginia	64 CSR 13 Minimum of 2 hours nursing personnel time/resident/day. Includes 0.4 hours of licensed nurse time and 1.6 hours of nurse aide time.		• In facilities with less than 60 beds, the DON may be included in the staff: resident ratio calculations. • Employees, private duty nurses, volunteers or contracted nurses who are "available" or "on call" do not meet the requirements for minimum staffing. • No individual shall be counted as meeting these numerical requirements on any 2 consecutive shifts, unless the facility can demonstrate extenuating circumstances and only then as a non-routine occurrence.
Wisconsin	Wisconsin Statutes, Chapter 50.04. Law requires that each nursing home shall provide at least the following hours of service by RNs, LPNs, or NAs: • For each resident needing intensive SNF care - 3.25 hours/day, of which a minimum of 0.65 hours shall be provided by an RN or LPN. • For each resident needing SNF care - 2.5 hours/day, of which a minimum of 0.5 hours shall be provided by an RN or LPN. • For each resident needing intermediate or limited nursing care - 2.0 hours/day, of which a minimum of 0.4 hours shall be provided by an RN or LPN. • HFS 132, the Wisconsin Administrative Code, is currently under revision and will be made consistent with Chapter 50.04.	• Each nursing home must have a charge nurse -- can be either an LPN under the supervision of an RN or MD, or can be an RN. • All facilities shall have at least one nursing staff person on duty at all times.	• Nursing waivers available, but rarely granted.
Wyoming	Wyoming Regulations. Regulations require: • 2.25 hours for each resident classified for SNF services in each 24-hour period, 7 days/week • 1.5 hours for each resident classified for intermediate care in each 24-hour period, 7 days/week	• Each nursing station shall be staffed with an RN or LPN who is the charge nurse on the day tour, 7 days/week. All other tours of duty shall be staffed with an RN or LPN. • If an LPN is in charge, there shall be a minimum of 4 hours consultation given to the facility/week by an RN when the LPN is on duty. • There shall be 24-hour nursing service with a sufficient number of qualified supervisory and supportive personnel on duty at all times to meet the total needs of patients.	